C. Christopher Allen, Ph.D., P.S.C.
Licensed Clinical Psychologist
111 Dennis Drive
Lexington, Kentucky 40503-2916
(859)-276-5243
Fax: (859)-260-1538

FAX COVER SHEET

Date: 11-1-2013

# of Pages: 3
(including cover sheet)

To:

Co/Dept:

Fax #: 203-306-3014

Phone #:

MESSAGE

Re: Release of info

KENTUCKY LICENSE NO. 820

C. Christopher Allen, Ph.D.
111 Dennis Drive; Lexington, Kentucky 40503
(859)-276-5243
Fax: (859) 260-1538

To whom it may concern:

We received a request for information from this fax number, but it did not include the name of the patient. I have attached a release form, and will need a copy of the requester's ID. If this is a public fax number, then please disregard this fax. Otherwise, if you have questions, please feel free to call or fax our office.

Thank you,

Office of C. Christopher Allen, Ph.D.

C. Christopher Allen, Ph.D.
111 Dennis Drive; Lexington, Kentucky 40503
(859)-276-5243
Fax: (859) 260-1538

AUTHORIZATION FORM

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

I authorize Dr. Allen and/or his administrative and clinical staff to release (please circle all that apply), progress notes, reports, information via professional communication (i.e. phone, mail or e-mail).

This information should be released to (fill in the name, address, and phone number of person to whom the information is to be released).

_____
_____
_____

I am requesting my psychologist to release this information for the following reasons: ("at the request of the individual" is all that is required if you are my patient and you do not desire to state a specific purpose.)

_____
_____

This authorization shall remain in effect until (fill in expiration date) ___/___/_____, or until (any event which relates to the individual or the purpose of the user or disclosure).

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure (i.e., disclosed by the recipient of this information to a designated third party) by the recipient of your information and no longer protected by the HIPAA Privacy Rules.

*X*_____ _____
signature of patient date

_____
If the authorization is signed by a personal representative (i.e., parent, guardian, etc.) of the patient, a description of such representative's authority to act for the patient must be provided.

Note: A parent or guardian must fill out these forms and sign for anyone under 18.